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Ethnographic Methods, Cultural Context, and Mental Illness: Bridging Different Ways of Knowing and Experience

SPERO M. MANSON

ABSTRACT *A self-perpetuating cycle of mutual noninteraction among anthropologists, program representatives, and scientific peer reviewers has led to the near absence of ethnography in the NIMH research portfolio. The ensuing inattention to the context and meaning of findings emanating from work supported by this agency has had enormous, but seldom appreciated, consequences. This commentary illustrates lessons learned in the course of integrating ethnographic, diagnostic, and epidemiologic techniques to study mental health problems among American Indians and Alaska Natives. These lessons demonstrate the benefits to be gained by building bridges across different ways of knowing, in terms of disciplines as well as cultures.*

As Trickett and Oliveri note in the overview to this special issue, a major motive for convening the workshop entitled "Ethnography and the Illumination of Sociocultural Processes"—and several others that have since followed—was to facilitate the revitalization of the Sociocultural and Environmental Processes Program within their branch of the Division of Neuroscience and Behavioral Science at the National Institute of Mental Health (NIMH). The need to do so stems, as they briefly recount, from the serious curtailment of NIMH sponsorship of social and behavioral research in the early 1980s, which was part of an explicit, far-reaching policy implemented by the Reagan administration. Though that policy no longer applies, its consequences are still felt.

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Anthropologists whose work was once supported, and then rebuffed, by the NIMH are understandably reluctant, in light of this recent history, to invest significant personal as well as professional resources to develop research grant applications for submission to the institute. As a consequence, they have, for the most part, removed themselves from the shaping of its portfolio and current policy. In turn, almost a generation of peer reviewers, who judge the scientific merit of these proposals, have grown up without the benefit of critical exposure to anthropological perspectives and methods. Hence, they often do not appreciate the relevance of ethnography and its unique contribution to explicating the phenomena of central importance to this particular sponsor. Nor are many program representatives within NIMH themselves knowledgeable of the field. Therefore, especially in a working environment heavily influenced by biomedical approaches to understanding, they are not likely to credit (and thus encourage) ethnographic forms of inquiry as investigative techniques that warrant sponsorship by their agency. Each of these circumstances has reaffirmed, in a circular and self-fulfilling fashion, the others, resulting in the paucity of sponsored ethnographic research that indexes the basic assumptions underpinning such attitudes and behaviors. No wonder, then, that the NIMH funds so little work of this nature.

This commentary speaks directly to ethnography, embodied in several forms, as one among many scientific tools required to address questions concerning mental health and illness, including but not limited to issues of definition, etiology, manifestation, assessment, prevalence, course, treatment, prevention, and promotion. Drawing from work at the National Center for American Indian and Alaska Native Mental Health Research, I illustrate below just some of the potential that resides within this manner of study for expanding an otherwise much more partial knowledge of these matters. Ironically, almost all of the efforts that give rise to these examples were supported by NIMH, but seldom were recognized by that agency and its representatives as ethnographic. I will return to this latter point at the close of the discussion.

The first example flows from our attempt in the early 1980s to extend new developments in epidemiological field methods to the study of alcohol, drug, and mental disorders among American Indians. Specifically, we sought to adapt the Diagnostic Interview Schedule (DIS) (Robins et al. 1981) for subsequent use as the central protocol to assess the psychiatric status of community-based samples of adults in three Native communities: the Blackfeet, Confederated Tribes of the Warm Springs Reservation (e.g., Sahaptin, Wasco, and Paiute), and the Hopi. The early phases of this work quickly suggested to us that, though one could administer the DIS in its original form to the populations in question, and obtain answers consistent with the response formats provided, the Diagnostic and Statistical

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Manual (DSM)–based symptoms and syndromes operationalized by this instrument were neither the only nor even the most familiar expressions of illness evident in the participating communities. Consequently, employing ethnolinguistic procedures, we interviewed a large number of key informants, selected for potential variation intrinsic to these tribal groups (e.g., age, gender, residence, and membership in special men's/women's societies), to elicit the local, cultural constructions of personal suffering and relevant explanatory models. This information then was incorporated into the DIS in a manner that permitted us to examine respondent status from three distinct points of view: the DSM, the indigenous framework, and their intersection (Manson et al. 1985). The results were quite instructive. First, it became clear that, among the Hopi, for example, there is no direct analog to major depression in their classificatory system. Second, major depression "maps" differently onto the five major Hopi illness categories that may be considered "depressive-like reactions." And, third, this last observation was related to distinct treatment strategies—namely, the emphasis on somatic or psychosocial intervention varied in terms of the predominance of certain types of symptoms, which were captured more distinctly by the local constructions than by the DSM categories.

The American Indian Vietnam Veteran Project (AIVVP), a congressionally mandated replication of the National Vietnam Veterans Readjustment Study (NVVRS) (Kulka et al. 1990) recently completed by the National Center for American Indian and Alaska Native Mental Health Research (Manson et al. 1996), offers several additional examples. Building upon our past work, we recognized the importance of standardized comparison as well as of possible cultural bias in the original survey instruments, which were designed for administration to White, African American, and Hispanic Vietnam veterans. Unfortunately, this dual concern with replication and cultural validity proved problematic, as anticipated by the foregoing discussion.

First, questions that appear in standardized instruments may be *incomprehensible* to members of different cultural groups. For example, among some AIVVP respondents, a question that asks about "feeling as if you were going mad" was interpreted as a question about anger rather than about one's sanity.

Second, some questions may be *unacceptable* to respondents from another culture. For example, asking whether an American Indian respondent has ever abused peyote, seen as either a religious sacrament or powerful medicine, must be approached with care and respect. Its callous inclusion in a list of questions about potentially abused drugs is a serious error that may threaten further participation in the study.

Third, some questions may prove irrelevant cross-culturally. Consider, for example, a typical query about social support: "About how often

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have you visited with friends at their homes during the past month? (*Do not count relatives*)." Especially within reservation communities, the extent and importance of kin-based relationships dictate that most friends are relatives, and that friends frequently are referred to in familial terms. Indeed, within this setting, a friend who is not a relative has little meaning or relevance to the notion of social support.

Finally, other questions either may pose incomplete answers or fail to consider local equivalents. For example, an interview of Indian veterans' service utilization patterns that asks extensively about state and Department of Veterans Affairs health services, but ignores the Indian Health Service, tribal programs, or even traditional healing options, has disregarded critical elements in the local service ecology. Likewise, questions that inquire whether the respondent has told a health care professional—but not a traditional healer—about a particular problem, which are used as indexes of help-seeking behavior and subsequent criterion threshold, overlook an important local equivalent that carries similar implications for severity of an illness.

The congressional mandate required that we employ the instruments from the NVVRS study, which included the Composite International Diagnostic Interview (CIDI) (as an updated substitute for the DIS) and the Structured Clinical Interview for Diagnosis (SCID). Various ethnographic techniques, however, permitted us to examine the capacities and rectify some of the cultural limitations of these measures.

The first approach addressed the form and content of the instruments themselves. Here, an investigative technique known as focus group interviews was used to obtain direct comment on and suggested revisions of the comprehensibility, acceptability, relevance, and completeness of interview items and areas of inquiry (Agar 1986; Agar and MacDonald 1995). In the AIVVP, one or two facilitators convened small groups of 4–10 participants from among tribal members at each of the reservation communities that comprised the study sites. Each group met in 8–10 two-hour sessions over a two-month period. Participants were recruited from segments of the local communities: namely, Vietnam veterans, relatives of Vietnam veterans, service providers working with Vietnam veterans, and tribal elders. Each has a unique and important perspective on the area of concern. The focus groups were run on a classroom-like model, but reversed, with the participants as teachers and the facilitators as students. Participants were presented with the original NVVRS instrumentation and systematically asked a series of questions designed to elicit their reactions to the items and suggestions for improvement. These questions included: "What does this question mean to me?" "Is the intended meaning easily understood?" "How would I ask this question of someone else?" "Might I en-

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counter resistance in obtaining an answer to this question?" "How could I rephrase the question to reduce such resistance?"

The lessons taught by these focus groups were wide-ranging. The implications for assessing the validity of the interview, however, are relatively straightforward. The general notion of war-related trauma as capable of adversely affecting soldiers, a central tenet of Posttraumatic Stress Disorder (PTSD), clearly resonated with local understandings. Moreover, focus group respondents had little difficulty recognizing many if not most of the specific symptoms of PTSD as the result of combat-related trauma. Stories of disturbed sleep, intrusive memories, avoidance, hypervigilance, isolation, and other such symptoms abounded.

Yet, despite this finding, it also became evident that certain items and constellations of symptoms were problematic in these communities, not unlike the example of major depression among the Hopi. The research team labored arduously to identify such items, to articulate alternatives, to understand the implications that subsequent modifications might pose for issues of comparability, and to devise creative means for informing the instrumentation along such lines. The modifications can be summarized as changes in question wording, length and construction, specificity, and question probes, which entailed offering alternative phrases. For example, based on focus group comment, it became apparent that the standard question in the CIDI with respect to foreshortened future was poorly understood by local tribal members. They suggested the following alternatives, which were incorporated into the interview protocol, and asked immediately after the original item: "After this experience, did you begin to live from day to day?" "After or since this experience, did you begin to think you would die early?"

When these two items were included in the diagnostic algorithm as additional possibilities for fulfilling Criterion C, the lifetime prevalence of CIDI-defined PTSD increased from 38.8 percent to 46.9 percent. Moreover, concordance between the CIDI and the SCID, which was administered independently by a clinician, improved substantially, from a *kappa* of .63 to a *kappa* of .80. Clearly, relevant cultural knowledge can be elicited, incorporated into the assessment process, and may make an important difference in diagnostic and epidemiological outcomes.

The second approach pursued in this study was the addition of context and depth through key informant interviews with veterans, family members, and the community at large, and through anthropological techniques such as participant-observation. Particular emphasis was given to the familial, community, and historical contexts within which the postwar experience of American Indian Vietnam veterans have unfolded. Understanding these contexts enabled us to better assess phenomena beyond

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symptoms, and functional impairment in particular, which is vitally important to both diagnosis and treatment.

PTSD has an enormous impact on a wide spectrum of activities of daily living. There may be, however, major differences among victims across cultures in regard to the degree of such impact within certain domains. For example, interviews in the early phases of the AIVVP repeatedly underscored the devastating consequences that social isolation, avoidance, and psychic numbing—hallmark symptoms of this disorder—have for American Indian veterans' interpersonal relationships, notably with family and clan. Stories often were told by mothers, sisters, and wives of the community's deep respect for their warriors, a status that is honored. Yet, virtually in the same breath, they voiced their frustration, despair, and fear, for these men proved to be distancing, unconnected, and unpredictable. Caught in a dilemma—obliged to defer to and seek counsel from these latter-day warriors, yet unable to relate to them in expected ways—family members find themselves at a loss: the same kind of loss the veterans experience in regard to their own social displacement. The salience of this appears to be much greater for them than for their white counterparts whose alienation from more nuclear families is unlikely to pose as widespread a disruption of personal identity. Conversely, in Indian communities, higher education and steady employment are more rare and contribute less to male identity than is the case in non-Indian communities. Hence, the inability, due to PTSD, to hold a job or continue formal education is far less impairing among members of the former. Differences of this nature underscore the importance of ascertaining the broader social and cultural contexts that illuminate the impact of disorder on the individual, family, and community.

This latter lesson was driven home even more forcefully by another effort in which I participated—as a steering committee member for a study conducted by Impact Assessment, Inc. regarding the *Exxon Valdez* oil spill. On March 24, 1989 the *Exxon Valdez* struck a reef and spilled over 11 million gallons of oil into the previously pristine Prince William Sound. The impacts were enormous, affecting flora, fauna, and humans alike. Subsequent study of these consequences revealed that residents of communities physically touched by the oil spill were at increased risk of major depression, generalized anxiety, and PTSD than those who were not (Palinkas et al. 1993). Significant differences were evident as well between Native and non-Native residents of the same villages, with the former exhibiting consistently higher rates of all three psychiatric disorders. Controlling for differential experience of prespill trauma reduced but did not eliminate these disparities. Ethnographic research conducted in tandem with the social impact assessment suggested at least one reason, firmly rooted in the cultural ways of the Native inhabitants.

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Subsistence activities—the taking of game, fishing, harvesting mollusks, and gathering edible plants or berries—were widely practiced by Native as well as non-Native residents of the affected communities. The oil spill seriously disrupted local subsistence efforts, forcing greater dependence on more costly market foodstuffs, with dramatic fiscal consequences for all concerned. But the subsequent interruption of subsistence activities had an even more dramatic impact among the Natives. They, unlike their non-Native counterparts, experienced subsistence as a process of enculturation. As grandfathers, fathers, and grandsons hunt or fish, and as grandmothers, mothers, and granddaughters gather, stories are shared about the creation, peoples' places in the world, the significance of the land, and special features thereof. These stories, and their reaffirmation through the manner in which subsistence proceeds, transmit core elements of the culture from one generation to the next. Their disruption, threatened by the spill, occasioned widespread fear and anxiety as to the continuity of long-held traditions, indeed the future of the culture. Further analyses of the data indicated differences in the prevalence of psychiatric disorders among Native respondents that varied in terms of their degree of participation in subsistence activities and strength of cultural identity, lending additional credence to this interpretation, first suggested by ethnographic inquiry.

The need for diagnostic formulations that better capture the complexity, especially the sociocultural context, of clinical conditions is not a new revelation (e.g., Strauss 1991). In this respect, high priority repeatedly has been given, though not previously realized, to the improvement of diagnostic practice by incorporating a cultural dimension in the assessment process (Fabrega 1987; Good and Good 1986; Hughes 1985; Kleinman 1988a). DSM-IV, for the first time, represents a serious attempt to enact such improvement (American Psychiatric Association 1994). This effort was fueled by mounting evidence that clinicians must attend to the patient's personal perspective, to his or her cultural identity, to cultural factors surrounding a patient's illness, to the influence of cultural factors on social environment and functioning, and to intercultural elements of the clinician-patient relationship (Guarnaccia 1996; Jones and Thorne 1987; Kleinman 1988b; Kleinman and Lin 1981).

The move to address these matters, which comprises my last example, began in 1991 with the formation of the NIMH-sponsored Group on Culture, Diagnosis, and Care, of which I am member. The history of our labors is chronicled elsewhere (Mezzich 1995; Mezzich et al. n.d.). The idea for a cultural formulation emerged from discussions of the need to add a cultural dimension to the DSM's multiaxial assessment schema. After further deliberation, the NIMH Group concluded that such an approach would not adequately serve the needs of a cultural formulation, which is

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more complicated and requires greater organizational flexibility. Consequently, a new schema was developed, building upon the five domains indicated above. The NIMH Culture, Diagnosis, and Care Group presented this method, for which it had coined the term "Cultural Formulation Guidelines" to the American Psychiatric Association (APA) DSM-IV Task Force. The Task Force responded positively but required pilot testing that subsequently was undertaken by the group, focusing on the four major U.S. ethnic minority populations: African Americans, American Indians, Asian Americans, and Hispanics. The results demonstrated the utility of the guidelines; the APA Task Force accepted the NIMH Group's recommendations and included the guidelines as Appendix I of the DSM-IV.

The DSM-IV Cultural Formulation Guidelines supplement the multiaxial diagnostic assessment and address difficulties that may be encountered in applying DSM-IV criteria in a multicultural environment. The cultural formulation provides a systematic review of the individual's cultural background, the role of cultural context in the expression and evaluation of symptoms and dysfunction, and the effect that cultural differences may have on the relationship between the individual and the clinician. *Culture, Medicine and Psychiatry* has initiated a regular case series that demonstrates the application of these ethnographically informed guidelines to a wide range of clinical circumstance (Manson 1996).

The above examples by no means exhaust the extent to which one can illustrate the critical role of ethnographic inquiry in bridging different kinds of knowledge and experience in regard to mental illness (and mental health). Our work simply represents a long and rich tradition that continues to yield valuable insights into this subject matter, albeit in progressively more rigorous fashion, with greater ties to assessment, epidemiology, and treatment than typically has been the case. The interesting question for me, which bears directly on the reason for the conference reported in these pages, is this: Why have a number of colleagues— fellow anthropologists, on one hand, and representatives of NIMH and its sponsors, on the other—in commenting on the work cited above, characterized it as not anthropological, or more specifically, ethnographic? The answer, I believe, lies in their narrow assumptions about what constitutes ethnographic research, assumptions that do not overlap in definition or form, but yet contribute to similar attributions, with frustrating outcomes. It will require a pointed and forceful agenda such as that described by Trickett and Oliveri to move us past such impasses. This conference represents the first step along that path.

NOTES

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REFERENCES CITED

Agar, Michael
1986 Speaking of Ethnography. Sage Series on Qualitative Research Methods, vol. 2. Beverly Hills, CA: Sage Publications.

Agar, Michael, and James MacDonald
1995 Focus Groups and Ethnography. Human Organization 54:78–86.

American Psychiatric Association
1994 Diagnostic and Statistical Manual of Mental Disorders. 4th edition. Washington, DC: American Psychiatric Association.

Fabrega, Horacio
1987 Psychiatric Diagnosis: A Cultural Perspective. Journal of Nervous and Mental Disease 175:383–394.

Good, Byron, and Mary Jo Delvecchio Good
1986 The Cultural Context of Diagnosis and Therapy: A View from Medical Anthropology. *In* Research and Practice in Minority Communities. Manuel Miranda and Harry Kitano, eds. Pp. 36–43. Washington, DC: U.S. Government Printing Office.

Guarnaccia, Peter
1996 Comments on Culture and Multiaxial Diagnosis. *In* Culture and Psychiatric Diagnosis. Juan E. Mezzich, Arthur Kleinman, Horacio Fabrega, and Delore Parron, eds. Pp. 335–338. Washington, DC: American Psychiatric Press.

Hughes, C. C.
1985 Culture-Bound or Construct-Bound? *In* The Culture Bound Syndromes. Ronald C. Simons and Charles C. Hughes, eds. Pp. 3–41. Dordrecht, The Netherlands: Reidel.

Jones, E. E., and A. Thorne
1987 Rediscovery of the Subject: Intercultural Approaches to Clinical Assessment. Journal of Consulting and Clinical Psychology 55:488–495.

Kleinman, Arthur
1988a The Illness Narratives: Suffering, Healing and the Human Condition. New York: Basic Books.
1988b Rethinking Psychiatry: From Cultural Category to Personal Experience. New York: Free Press.

Kleinman, Arthur, and T. Y. Lin
1981 Normal and Abnormal Behavior in Chinese Culture. Boston: D. Reidel.

Kulka, Richard A., William E. Schlenger, John A. Fairbank, Richard L. Hough, B. Kathleen Jordan, Charles R. Marmar, and Danial S. Weiss
1990 Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study. New York: Bruner/Mazel Publishers.

Manson, Spero M.
1996 The Wounded Spirit: A Cultural Formulation of Post-Traumatic Stress Disorder. Culture, Medicine and Psychiatry 20:489–498.

Manson, Spero M., Jan Beals, Theresa O'Nell, Joan Piasecki, Donald Bechtold, Ellen Keane, and Monica Jones
1996 Wounded Spirits, Ailing Hearts: The Nature and Extent of PTSD among American Indians. *In* Ethnocultural Aspects of Post-Traumatic Stress and Related Disorders.

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Anthony J. Marsella, Matthew Friedman, Elaine T. Gerrity, and Raymond M. Scurfield, eds. Pp. 255–283. Washington, DC: American Psychiatric Association Press.

Manson, Spero M., James H. Shore, and Joseph D. Bloom

1985 The Depressive Experience in American Indian Communities: A Challenge for Psychiatric Theory and Diagnosis. *In* Culture and Depression. Arthur Kleinman and Byron Good, eds. Pp. 331–368. Berkeley, CA: University of California Press.

Mezzich, Juan E.

1995 Cultural Formulation and Comprehensive Diagnosis. The Psychiatric Clinics of North America 18(3):649–657.

Mezzich, Juan, Laurence Kirmayer, Arthur Kleinman, Horacio Fabrega, Delores Parron, Byron Good, Keh-Ming Lin, and Spero M. Manson

N.d. The Place of Culture in DSM-IV. Journal of Nervous and Mental Disease.

Palinkas, Lawrence A., Michael A. Downs, John S. Petterson, and John Russell

1993 Social, Cultural, and Psychological Impacts of the *Exxon Valdez* Oil Spill. Human Organization 52(1):1–13.

Robins, Lee N., John Helzer, J. Croughan, and Katherine Ratcliff

1981 National Institute of Mental Health Diagnostic Interview: Its History, Characteristics, and Validity. Archives of General Psychiatry 38:381–389.

Strauss, John S.

1991 A Comprehensive Approach to Psychiatric Diagnosis. American Journal of Psychiatry 132:1193–1197.

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